American Association of Intellectual and Developmental Disabilities-South Carolina Chapter

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Dual Diagnosis

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Dual Diagnosis

- DEFINITION: Presence of at least one psychiatric disorder OR maladaptive behavioral pattern and an intellectual disability (MR/ DD).
- Past- psychiatric disorders were “rare” in persons with MR/ DD.
- If diagnosis made -> Psychosis
- Yet- HIGH rates medication use, especially antipsychotics

1993- Annals Clinical Psychiatry: Rojahn, et al

- Normal lifetime incidence Affective/ Mood Disorders- 20% in women, 12% in men
- New York MR/ DD program – 45,683 patients served- only 21 diagnosed with mood or affective disorder (0.046%)
- California MR/ DD program- 89,419 patients served- only 599 diagnosed with mood/ affective disorder (0.67%)

Recent Studies (mid 1990's to current)

- Coexisting Psychiatric Disorders MORE COMMON than general population!!!
- 27- 71% of MR/ DD population
- Institutional settings > Community
- Schizophrenia/ Psychosis over diagnosed
- Mood/ Anxiety Disorders often missed

Why Is This Important???

- Most common reason for failure to transition to community.
- Much higher rates institutionalization.
- High rates hospitalization, client/ staff accidents/ injuries, re- hospitalizations.
- Pain and Suffering of untreated mental illness.

Who's To Blame???

- Psychiatrists AND MR/ DD professionals !!!
- DSM IV- TR criteria- depend on subjective "feelings/ thoughts"- require verbal skills and are subjective.
- Behavioral "Overshadowing"- seen as "Normal" behaviors for MR/ DD persons.
- Psychiatrists/ physicians- little to no training.
- Dichotomy- EITHER Behaviors OR Disorder.
- Medication "masking" of symptoms.

Blame- cont.

- Applied Behavior Analysis- focus on “modifying” behaviors- may miss an actual disorder.
- Lack of literature/ studies- especially good large studies.
- Lack of cross training & exposure.
- Focus on “Disruptive” behaviors- may miss depression/ anxiety until real late.

Psychosis

Psychotic Disorders

- Schizophrenia- as defined DSM IV TR- probably NO different than in “normal” population (1 -2%). (Reiss, et al 1994)
- DSM criteria “work” for Mild- Moderate MR, difficult to adapt criteria for severe to profound.
- Dx: Psychotic Disorder NOS- (possibly more common than general population???)
- BE CAREFUL- hallucinations. Normal for people under developmental age 6 -> have “imaginary” friends, say they “hear” voices, confuse current events with past, talk to themselves, etc. Often choose last choice in “list” of questions.
- Generally -> schizophrenia will need chronic (lifelong) treatment with antipsychotics

Psychosis- cont.

- WHY differentiate Schizophrenia vs. Psychotic Disorder NOS?
- AJMR- (1994-Pary et al), looked at 84 patients on chronic antipsychotics, 68 felt “stable” enough to taper off.
- Hx. of psychotic sx.’s-> STRONG predictor of restarting antipsychotics
- No history psychosis-> predicted ability to come off antipsychotics.
- However- 1/3 with a history psychotic symptoms were still OFF ANTIPSYCHOTICS at 12 months follow-up.

Psychosis- cont.

- Newer Atypical antipsychotics are typically used. Lower rate of side effects, better tolerability than older “typical” antipsychotics.
- Most can be transferred to atypicals, but 5- 10% fail and need to stay on “typical” antipsychotics- (Galluchi, et al, Mental Health Aspects of Dev. Dis. 1/2003).
- Psychosis is common-> Velocardiofacial Syndrome (30+%), PKU, Prader Willi Syndrome (5- 10%).

Antipsychotic Classes

- Typicals- Thorazine, Mellaril, Trilafon, Haldol, Navane, Prolixin, Stelazine, etc.
- Typicals primarily block Dopamine activity.
- Atypicals- Zyprexa, Risperdal, Seroquel, Geodon, Abilify, and 3 new ones- Invega, Fanapt, Solian. Clozaril (clozapine) is also an atypical, it was actually the first atypical. All atypicals have both dopamine and serotonin receptor effects.

Typicals vs. Atypicals

- Tardive Dyskinesia- major risk of antipsychotics in past. Typicals-> 30% lifetime risk. Abnormal involuntary movements- tongue thrusting, lip pouting/ smacking, shoulder shrug, hand movements, etc. Atypicals have much lower rate of TD.
- Metabolic Syndrome- weight gain/ obesity, glucose intolerance/ AODM, elevated lipids, HTN-> increased risk with atypicals!!! Get baseline values, then periodically monitor above. Emphasize healthy diet, exercise, avoid “empty” calories.
- “Substituted” one risk for another! All antipsychotics are about equally effective, atypicals just have (overall) a better side effect profile. Clozaril is probably exception.

Mood Disorders

Mood Disorders- Depression

- Probably higher rates than general population.
- Mild MR- often presents with “typical” depressive symptoms (sadness, appetite/ sleep changes, lethargy, loss of interest, etc.).
- More severe/ profound MR/DD-> “atypical” symptoms- aggression, SIB, screaming, property destruction, etc.
- Look for vegetative symptoms- (Insomnia/ hypersomnia, weight gain/ loss, lethargy), Can also see loss of interest, crying, guilt, anxiety, suicidal thoughts, etc.
- Treatment- antidepressants/ therapy.
- Higher likelihood of “activation” on antidepressants than general population.

Mood Disorders- Depression

- Activation -> is it undiagnosed Bipolar???
- Charlot, et al- irritable mood is the common presentation in those diagnosed w/ depression-> 75% aggression, 50% SIB.
- Down's Syndrome, Head Trauma, Fragile X Syndrome, Williams Syndrome, Turner Syndrome, all may be at increased risk.

Rule Out Medical Illnesses

- Gen. Hosp. Psychiatry (1997, 19:274-280)
- 1135 patients referred to psychiatric clinic.
- All medically “evaluated” prior to clinic -> rule out medical cause for behaviors
- 75% found to have undiagnosed/ inadequately treated medical problems!
- In 25% referrals- psychiatric symptoms resolved/ improved after tx. of Medical problems
- Seizures, hypothyroidism (12.7%), GERD/ ulcers, pain (acute/ chronic), dental abscess, VP shunt failure, etc.

Mood Disorders- Bipolar Disorder

- Possibly increased incidence-> 3- 8%. Is this “true” bipolar or function neurologic injury???
- Mixed/ rapid cycling most common pattern. Can see hyperactivity, less sleep needed, screaming/ yelling, increased sexual activity, racing thoughts, euphoria, grandiosity, “cyclical” pattern over days to months.
- Sometimes seen after start antidepressants.
- Anticonvulsants- Depakote & Tegretol, May need higher blood level for anticonvulsant than is used for seizures (Valproic acid > 100 or Tegretol/ carbamazepine level 9- 12).
- Occasionally Lithium

Mood Disorders- Bipolar- cont.

- Atypical antipsychotics- often used as adjuncts.
- Bipolar is frequently misdiagnosed.
- Limited studies. Charlot, et al found over 40% diagnosed Bipolar referred due to SIB
- Bipolar depression- Lamictal or lithium
- Common- Velocardiofacial syndrome (30%), Brunner Syndrome (MAO A deficiency)

Anxiety Disorders

Anxiety Disorders

- Anxiety is subjective, may have trouble reporting it. Often presence of anxiety is inferred from behaviors.
- All types described- Panic Disorder, Generalized Anxiety Disorder (GAD), Obsessive Compulsive Disorder (OCD), Phobias, Post Traumatic Stress Disorder (PTSD)
- Rely on behavior, “clues”, responses (ex.- agitation in certain settings) for evidence of anxiety

Anxiety Disorders- cont.

- PTSD- under recognized. Frequently misdiagnosed- (ex.-schizophrenia). Our individuals prone to abuse (unfortunately!)
- OCD- common, watch for “self restraint”
- TIPS- avoidance behaviors, agitation only in certain situations, autonomic arousal (dilated pupils, increased HR/ respirations)

Anxiety Disorders- cont.

- Treatment- antidepressants (both SSRI's and SNRI's), Buspar (buspirone)
- Watch Out- benzodiazepines (valium, ativan, xanax, klonopin, etc.) Can cause DISINHIBITION (agitated/ confused, acting drunk)
- Common- Fragile X, Prader Willi (50% are OCD), Autism, Williams Syndrome, Turner Syndrome

Other Disorders

Attention Deficit Hyperactivity Disorder (ADHD)

- Usually combined type- inattention AND hyperactivity/ impulsivity
- Incidence at least as high , probably higher-> 4-18% in various studies
- Compare to peers at same developmental age/ level
- Psychostimulants- very effective in school age group (possibly less in IQ < 45 ?). Ritalin, Adderall , D amphetamine, Concerta, Vyvanse, etc. all used.

ADHD- cont.

- Psychostimulants- Higher rates-> Tics, agitation/ irritability, social withdrawal than in “typical” children with ADHD.
- Central Alpha- 1 Presynaptic agonists (clonidine, Guanfacine/ Tenex, Intuniv) also good for impulsivity/ hyperactivity.
- Occasionally- antidepressants (SSRI’s)
- Watch for undiagnosed Bipolar Disorder

Impulse Control Disorders

- R/O Mood or Anxiety Disorder, Psychotic Disorder.
- R/O Medical problems/ seizures/ pain/ other medical issues.
- Medication side effects
- Environmental change, stressors, etc.
- Other changes in person's life?
- If not, then consider Impulse Control Disorder NOS

Substance Abuse Disorders

- Some estimates- as many as 10% MR/ DD population.
- Tend to be Mild- Moderate range. Substances tend to be very disruptive, if anything can have exaggerated effects compared to normal population.
- What is “safe” level of use??? In my opinion- same as pregnancy-> NONE!
- Treatment-> modified, 12 step with recovery “guide”, consider residential setting or ½ way house, individual therapy, etc. Goal is complete abstinence. Medications have very limited role here.

Eating Disorders

- Anorexia and Bulimia-> rare in MR/DD population.
- Pica- common- occasionally can have severe medical complications-. Gastric/ intestinal perforation, etc. Can be very difficult to treat- try to identify “causes” if possible. Make sure not eating things due to nutritional deficit.
- Rumination- try to identify “cause” is it anxiety/ medical issues, etc. Again, difficult to treat sometimes. Can be very damaging to esophagus, teeth, etc.

Tic Disorders/ Sterotypies

- Try to establish Hypothesis of cause-> anxiety, self stimulation, etc. Treat usually if severe, and disruptive to function (Self injury, significant impairment, etc.)
- Tourette's Disorder also fairly common. Low dosages atypicals may help if severe.
- Tics are also more common in MR/DD, can worsen with stimulants, occasionally other medications.
- Self stimulation common in some disorders-> Autism, occasionally fragile X, Angelman Syndrome, Prader Willi, etc.

Personality Disorders

- Usually only diagnosed mild, sometimes moderate DD. Personality Disorder defined as “chronic, lifelong pattern of maladaptive behaviors in multiple different settings of individuals life”.
- All types described. Can be over diagnosed, “maladaptive behaviors may be appropriate response to a dysfunctional environment”.
- Our individuals CAN participate in psychotherapy!!!. Will need to make some changes in approaches, but definitely should be considered.

Autism

- Currently Five in autistic “spectrum”- Autism, Retts Syndrome, Aspergers Syndrome, Childhood Disintegrative Disorder, Pervasive Developmental Disorder N.O.S.
- Classic TRIAD-> impairments in reciprocal social interaction, communication, and restricted or repetitive patterns of behavior, interests, and activities.
- No medications really effective with “core” autism features

Medications/ Autism

- Risperdal and Abilify- recently approved for “behavioral outbursts/ problems” associated with autism.
- Often have co- existing disorders- OCD, mood/ anxiety disorders, etc. Some individuals benefit w/ medications “targeted” for disorders/ behaviors associated with autism.
- Best way to evaluate-> “Do benefits of medication outweigh any associated risks”???

Summary

- Psychiatric Disorders VERY common in MR/DD population
- Atypical presentations common
- Psychotic D/O over diagnosed, others tend to be missed
- Persons with MR/DD at increased risk side effects, have difficulty reporting
- Also increased risk medical problems

Summary

- “Behavior problems” are NOT part of “normal” features of MR/ DD, and should trigger a look for possible psychiatric or medical disorder
- MR/ DD is a “COGNITIVE and LEARNING disorder” (not behavior disorder)

Questions???

Social/ Environmental Issues Facing Persons with Developmental Disabilities

Social/ Environmental Issues

- Impaired cognition, flexibility, poor impulse control, poor coping/ social skills
- Crowding, noise, multiple moves, aggression by others
- Overly dependent on nuclear family
- Lack of “social support system”, few friends, overly dependent on a limited number of people

Social/ Environmental Issues

- Lack of social awareness, poor understanding of boundaries, “safe” touch
- Families-> children w/ MR-> MUCH higher divorce rates, higher rates of physical/ sexual/ emotional abuse of child w/ DD/ MR
- Effects of caregiver medical/ mental illness?
- Death in family-> MAJOR IMPACT!
- It is stressful and challenging to care for someone w/ MR/DD!
- Often have 1 parent leave-> Single parent home

Social/ Environmental

- Effects on siblings- can range from embarrassment/ shame all the way to overprotection. Often "frustrated"/ angry at not being "a normal family"
- Many parents overprotective, sometimes to the point of "sheltering individual" from life experiences
- Again, MR/DD individuals at increased risk physical/ sexual/ emotional abuse or exploitation
- "Check" can be source of funds- will sometimes keep individual at home to ensure check continues- Referral social support agencies for assistance???